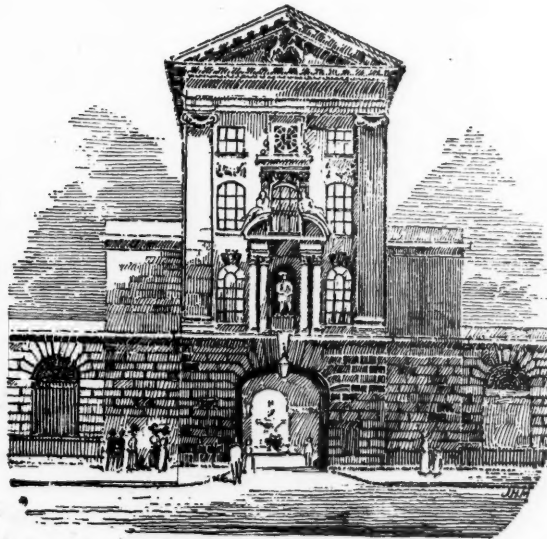


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ST BARTHOLOMEW'S HOSPITAL JOURNAL



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"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXIX.—No. 11.]


AUGUST 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

Tues., Aug. 1.—Sir T. Horder and Sir C. Gordon-Watson on duty.
Fri., „ 4.—Prof. Fraser and Prof. Gask on duty.
Mon., „ 7.—Bank Holiday.
Tues., „ 8.—Dr. Morley Fletcher and Mr. Waring on duty.
Fri., „ 11.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Tues., „ 15.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
Fri., „ 18.—Sir T. Horder and Sir C. Gordon-Watson on duty.
Sat., „ 19.—Last day for receiving matter for September issue of the JOURNAL.
Tues., „ 22.—Prof. Fraser and Prof. Gask on duty.
Fri., „ 25.—Dr. Morley Fletcher and Mr. Waring on duty.
Tues., „ 29.—Dr. Drysdale and Mr. McAdam Eccles on duty.

EDITORIAL.

E offer no apology for making this month's Editorial Notes as short as possible. We would make them shorter if we could. For this is the holiday month when our seniors are absent from wards and consultations and laboratories, gaining health and strength to grapple with another year's teaching. There is, however, a bright side to the sombre picture for us who remain. The Chief Assistants now come into their own. They walk across the Square with an added weight—we might almost say the droop of premature age—about their shoulders. Great and terrible is their responsibility these summer days, and well they bear the strain.

To all our readers we wish a very happy holiday, well knowing that after a year's work at Bart.'s none can deserve it better nor enjoy it more.

We are delighted once again to see the post-graduates with us. They represent not only past generations of Bart.'s men (and therefore command our respect and affection), but the most enlightened and progressive type of general practitioner. We welcome them back to the place whose traditions they maintain and which we in our turn inherit. We wish that one of them might lecture to us on the difficulties of general practice.

* * *

The recent inaugural dinner of the Tenth Decennial Club was a very great success. Over seventy members were present. We congratulate Dr. Stott and Mr. Reginald M. Vick upon the event.

* * *

The latest sister society of our own Abernethian Society is the recently established Cambridge University Medical Society. Dr. Langdon Brown delivered the inaugural address. We hope and predict great success for the Cambridge enterprise.

* * *

Our heartiest congratulations to Mr. Elgood in securing the third place in the King's Hundred at Bisley. This is brilliantly better than his place last year of thirtieth.

* * *

We have recently seen a set of engravings, produced by Messrs. Beynon, of Cheltenham, and now on sale in the Library. The drawings are of Hospital subjects well known to Bart.'s men and nurses, to whom we commend them. They are of great artistic charm and merit, and one or more should be on the walls of every student, past or present, of the Hospital.

THE OCTOCENTENARY OF THE FOUNDATION.

3. THE BEADLES.

By SIR D'ARCY POWER, K.B.E.



FTEN in the Hospital Square, sometimes in Cheapside, more rarely in Oxford Street, a pleasant-looking official may be seen in a wide-skirted black coat with a silver badge on his right breast bearing the Hospital arms and wearing the regulation cap of black with a narrow white piping—the Hospital colours. He is one of the Hospital beadles, and he takes us straight back to the re-foundation of the Hospital, and to the days of Henry VIII. He is as much a part of the Hospital as the Clerk or the Surgeons and even more so, because he is a parish officer as well as a Hospital servant, and he came into existence when the parish of St. Bartholomew's-the-Less was established in 1547. His duties both as a Hospital official and as a parish beadle were clearly defined from the very beginning. His charge as a beadle was that—"Your office and charge is to give attendance from time to time upon the Governors of this House, and to do such business as they shall assign to you. On all such days as the Governors of this House shall not sit in this Hospital for the affairs of the same ye shall separate and divide yourselves into the sundry parts and liberties thereof every man taking his several walk. And if in any of your walks ye shall happen to espy any person infected with any loathly grief or disease, which shall fortune to lie in any notable place of this City to the noyance and infection of the passers by and slander of this House, ye shall then give knowledge thereof to the Almoners of this Hospital that they may take such order therein as to them shall be thought meet.

"Ye shall also have a special eye and regard unto all such persons as have been cured and healed in this House that none of them counterfeit any grief or disease, neither beg within the City and liberties thereof. And if ye shall fortune to find any so doing, ye shall immediately commit him, or them, to some cage and give knowledge thereof to the Governors of this House, that they may take further order as they shall think best.

"Ye shall not haunt nor frequent the company of any poor and beggarly persons (that is to say) to drink or eat with them in any victualling house or other place, neither shall ye receive any bribe or reward of any of them, lest by occasion thereof you should winck at them, and so lowly licence them to beg, upon pain to be dismissed this House.

"Also ye shall not suffer any sturdy or idle beggar or vagabond to beg or ask alms within this City of London or the suburbs of the same, but ye shall forthwith commit all such to ward and immediately signify the name and surname

of him or them to the Alderman of that ward where ye shall apprehend any such beggar or else to the Lord Mayor that execution may be done as the law in that case provideth. This is your charge."

In addition to this charge relating to the main duties of the beadles there exist the more detailed orders for the beadles, which are of equal interest. They are:

"First, you shall every day, two and two together, walk through your wards appointed with your staffs in your hands; and all such vagrant and idle persons as you shall find in your walks or in any place abroad, you shall apprehend and convey to the Bridewell. And if you chance to be resisted by way of the said vagrants and evil persons you shall call for aid to every constable next adjoining to assist you. And if he refuse to do so, to take his name and go to the Lord Mayor and deliver unto him the disobedience of the said constable. And if the Lord Mayor do not presently cause such constable to be punished, then at the next Court of Aldermen you to attend and make your complaint, whereby the law may be executed accordingly.

"Item, if any of your citizens die within your walks you are to give your attendance at the houses of them so deceased and to see that no rogues or idle persons resort thither to trouble the street. And if anything be given you of benevolence for your travail to take it thankfully without calling aught of duty. And if you be not of yourselves able to clear the streets of such; then you shall call to your aid such beadles whose walks are next adjoining to aid and assist you therein. And you shall distribute to them part of such money as shall be given unto you. And you shall not intrude yourselves to none other burials out of your wards or walks but unto such as you shall be called by your fellow beadles.

"Item, one of you every Sunday with the rest of the beadles of the other houses shall give your attendance at Paul's Cross at the sermon time; to visit all the streets and lanes adjoining and there to apprehend all such vagrant and idle persons as shall be there found by you, and to carry them as well men as women and children to Bridewell; whereby there may be order taken according to the law prescribed.


"And if any of you shall be found negligent in performing these orders above said or any other orders hereafter made and devised, upon every fault found your staffs shall be taken from you and to be secluded for evermore for serving in those rooms. Whereof assure yourselves without any favour or otherwise to be punished according to the Governors' discretion."

It is clear therefore that the beadles of the Hospital were persons of importance in the City, that they had ample authority to maintain order, apprehend rogues and compel the sick who were a menace to public health to come to the Hospital for treatment. They are now reduced to two, and are to be clearly distinguished from the "box carriers"

who used to attend the surgeon as he went his rounds in the wards, one being attached to each. The box carrier derived his name from the heavy brass-bound box of instruments which he carried when minor operations in the wards were performed on the spur of the moment without an anæsthetic. He was at once a terror to the dresser and a help to the house-surgeon. His heavy step slowly ascending the stairs in the middle of the night was a warning to the house-surgeon of a loud knock on his bedroom door, followed by "A case in the Surgery, Sir, but you needn't 'urry for it ain't hurgent," or else "I think you'd better come quick for 'e seems pretty bad."

THE PITUITARY GLAND IN ITS RELATION TO OBSTETRICS AND GYNÆCOLOGY.*

By Dr. HERBERT WILLIAMSON, F.R.C.P.

ENTLEMEN,—When I was asked to give two lectures in the Post-Graduate Course, I asked myself in what direction the greatest advances had been made in obstetrics and gynæcology during the last few years. I came to the conclusion that it was in the recognition of the part played by the ductless glands in causing derangements of the reproductive functions.

Let us, as an example, consider the question of menorrhagia. Until recently we recognised two groups of cases—those associated with general diseases, and of these, perhaps, the anæmias and lesions of the mitral valve were the two commonest, and those found in connection with local pelvic conditions. But there were many cases in which we found neither local nor general cause for the symptoms. We then tried drugs, and if these failed, as they very frequently did, we curetted and made a microscopic examination of the curettings. And in time the report came back to us with the blessed word "endometritis." May I here make a remark about endometritis. The uterine mucous membrane is not the same in appearance on any two days of the menstrual cycle. Look at this, and this, and this [here three plates were shown on the epidiascope]. All these are from a normal uterus, and yet the microscopic appearances are entirely different. If you send a specimen of curettings to a pathologist you should tell him upon what day of the menstrual cycle it was taken.

We now recognise that the cause of menorrhagia must often be sought in the ductless glands, the ovary, the thyroid, the pituitary—each or all may be responsible. Curetting is seldom done now save for diagnostic purposes. If you cannot find any other cause for menorrhagia think of the ductless glands.

The profuse menorrhagia of puberty is frequently due to hyperthyroidism, and in these cases the basal metabolic

rate is usually raised. Let me here give you a word of warning. Some would have us treat this condition of the thyroid with X rays. I regard this as dangerous. Certainly the menorrhagia is stopped, but I have known two cases in which permanent amenorrhœa resulted.

Other types of menorrhagia are associated with excessive production of lutein tissue or of excessive secretion of the anterior lobe of the pituitary body.

Menstruation is entirely dependent upon ovulation. A hyperactivity of the lutein-tissue produces menorrhagia; a hypoactivity will give scanty menstruation or amenorrhœa. But let us go further back. What excites ovarian activity? We cannot give a complete answer to this question, but we do know that the thymus, the internal secretion of the mammary gland, the suprarenals, all inhibit ovarian activity. It is at puberty, when the thymus atrophies, that ovulation commences; during lactation there is amenorrhœa: the suprarenal tends toward the male characteristics. The thyroid and the anterior lobe of the pituitary stimulate the ovary to activity.

There is an old saying that a woman is a woman because of her ovaries. This statement requires modification, for that combination of attributes, physical, psychic, and mental, which in their sum total constitute "femininity," depends not merely upon the presence of ovaries, but upon the whole system of inter-related and inter-acting endocrine glands.

Let me quote two cases in proof of this. This appears to be the picture of an attractive young woman. The body contour, the rounded limbs, the well-developed breasts, the distribution of hair upon the body, the very poise of her head as she is being photographed, are typically feminine. The external genitals were well formed, but the vagina was short and ended blindly. Because of certain vague symptoms the abdomen was opened by Dr. Russell Andrews. There was no trace of a uterus or Fallopian tubes, but two gland-like bodies were found attached by thick bands to the posterior abdominal wall. One was removed, the other left. I show you a picture of the microscopic section of this gland; it is composed, as you see, of seminiferous tubules with numbers of interstitial cells. It is a testicle.

The other case was described by Dr. Gordon Holmes at a meeting of the Association of Physicians in May, 1921:

Dr. Gordon Holmes related a case of tumour of the suprarenal cortex in a young woman. Her development was normal until the age of 19. Then menstruation ceased suddenly and the secondary sexual characteristics underwent very marked changes—atrophy of the mammæ and appearance of coarse hair on the lips, chin and body. Her configuration became essentially male. The clitoris enlarged and the uterus was very small. Sugar tolerance was considerably raised. A tumour was felt in the right side of the abdomen which gradually increased in size. It was removed, and was found to be encapsulated with a structure micro-

* An account of two lectures in the Post-Graduate Course.

scopically resembling normal suprarenal tissue. The patient menstruated twenty-six days after its removal for the first time for some years, and the male characteristics rapidly disappeared. She now appeared to be quite normal. Photographs were shown illustrating her appearance before and after the removal of the tumour.

Before proceeding to discuss the pituitary gland more fully let me give you a word of warning. The study of endocrinology is yet in its infancy. The experimental evidence is often contradictory. Clinical facts do not always fit in with laboratory conclusions. There is at present much unfounded speculation. Great caution is therefore necessary in accepting conclusions.

The pituitary body lies in the sella turcica, and the situation furnishes us with one method—the X-rays—of confirming diagnosis of pituitary enlargement. Its weight is $1\frac{1}{2}$ grm. and it is one of the most vascular organs in the body, for twenty to twenty-six arterioles supply it. It is composed of three parts—the pars anterior or glandularis, the pars intermedia and the pars nervosa, the latter two together forming the posterior lobe. The pars anterior, developed from Rathke's pouch, discharges its internal secretion direct into the blood and lymph-spaces. During pregnancy a new type of cell is found in the anterior lobe, so that a competent pathologist on examining a pituitary gland can tell you whether the patient from whom it was taken was pregnant or not. The pars intermedia manufactures a secretion which passes through the pars nervosa into the cerebro-spinal fluid contained in the third ventricle. As is well known, each of the parts of the pituitary exhibits marked microscopic differences.

When we study the physiology the problem is a complicated one, and we are soon forced to the conclusion that the anterior and posterior lobes have different functions. The anterior lobe is intimately associated with the process of growth and with the development of the sex-glands.

From the posterior lobe an active extract can be obtained which—

- (1) Raises the blood-pressure and strengthens the heart's beat.
- (2) Constricts the coronary artery.
- (3) Causes contraction of unstriated muscle, of the uterus, the bladder, the intestines.
- (4) Stimulates the secretory activity of the renal cells.
- (5) Dilates the renal vessels.
- (6) Causes a temporary (but not permanent) increase in the flow of milk.
- (7) Produces glycosuria by causing disappearance of glycogen from the liver and diminishing carbohydrate tolerance.

If the anterior lobe be partially removed in a young animal we find—

- (1) Deficiency of growth.
- (2) Imperfect ossification of bones.

- (3) Failure of development of the sexual organs.

If removed in an adult animal we find atrophy of the sexual organs.

If young animals are fed on the anterior lobe of the gland we find—

- (1) Very early functional activity of both ovaries and testes, with early manifestations of sexual maturity.
- (2) Early oögenesis and spermatogenesis.

A remarkable experiment was recently performed to ascertain the effects of feeding laying hens on pituitary substance: 655 hens were kept under observation upon a fixed diet and under constant conditions. They laid 233 eggs per diem; after adding pituitary gland substance to their food for four days the daily average rose to 352 eggs per day.

No active extract has ever been prepared from the anterior lobe. No graft of the anterior lobe has ever lived long enough to permit of observations of any value, but from the evidence I have quoted and from other evidence I might quote if time permitted, these functions of the anterior lobe have been firmly established.

In practice instances of anterior lobe deficiency often come under the observation of the gynaecologist. The patients are brought because they have passed the usual age of puberty, but they have failed to develop sexually and the periods have not been established.

Here is a remarkable instance of such a condition. This girl, at the time the photograph was taken, was 19 years of age; she measured 4 ft. 3 in. in height and had never menstruated. As you see, the secondary sexual characters are lacking: the female configuration, development of the mammary gland and of pubic hair are not present.

Minor degrees of this same deficiency are common in practice, and many cases of late puberty, imperfect development of the uterus with its attendant painful menstruation and menstrual irregularities are due to this cause. It is of great importance to detect them early, for by timely treatment years of mental and bodily suffering may be averted from these unfortunate girls.

The clinical manifestations of deficiency of the anterior lobe of the pituitary body are, then, in the severer grades pituitary infantilism, and in the milder grades delayed puberty, with an ill-developed uterus with dysmenorrhœa. Therefore, to girls with late menstruation, with scanty, painful periods and with a small, ill-developed uterus I give the following extract of ductless glands: 2 gr. of the whole pituitary gland and 5 gr. of extract of whole ovarian gland twice daily, with 1 gr. of extract of thyroid gland at night. These may be combined in capsules for convenience. With regard to ovarian extract, it should be recognised that there are three forms: one is extract of corpus luteum, another is extract of the whole gland, and another is extract of ovarian residue. I give, in these cases, extract of the whole gland.

Anterior lobe deficiency in adults may be manifested as Fröhlich's syndrome or dystrophia adiposo-genitalis. The chief symptoms of the condition are the deposit of fat, especially in those places where fat is normally plentiful in the female, such as the abdomen, the buttocks, and the proximal portions of the limbs. Associated with the fat, and apparently in the subcutaneous fat, are painful hard swellings, transitory in nature. There is amenorrhœa and a high sugar tolerance. The treatment is by administration of extract of pituitary.

Excess of the anterior lobe brings about gigantism before the ossification of the epiphyses is completed; afterwards, acromegaly.

In the early stages of each there is increased sexual activity; later, as degeneration occurs, sexual inactivity. Therefore, just as with the thyroid gland we have hyperthyroidism associated with Graves's disease and hypothyroidism leading to myxœdema, so we have hyper- and hypo-pituitarism. But the problem of the pituitary is more complicated than that of the thyroid, because as degenerative changes occur in the gland hyperpituitarism passes into hypopituitarism, and in an organ with two lobes, each having a separate function, one may be over-active and the other under-active. For instance, a tumour of the anterior lobe may press on the posterior lobe and we may get dyspituitarism—that is, a group of manifestations which are not those of either hyper- or hypo-pituitarism.

Now let us consider the use of posterior lobe extracts. First, you must know what preparation you are using, for the product of one leading firm of manufacturing chemists is double the strength of another.

My advice to you is, if you use pituitary use it in small doses—never stronger than 1 c.c. of 10 per cent. in labour. I regard 1 c.c. of 20 per cent. as a dangerous dose. If, therefore, you use a 20 per cent. solution, use not more than half a cubic centimetre, for we know that the result of the injection of pituitary extract may be uterine tetanus or tonic uterine contraction. Now let us consider the use of pituitary extract in pregnancy—and I should like to mention that the discovery of the effect of pituitary extract on uterine contraction is due to an old Bart.'s man, an old house-physician of Dr. Gee's—Dr. Dale.

Primary uterine inertia may occur in successive pregnancies, and it has been suggested that it is a preventable condition. If, late in pregnancy, the uterus tends to remain flaccid under your hand, the probability of the condition is suggested. Give calcium lactate together with 3 or 4 minims of 2.5 per cent. solution of pituitary as a prophylactic during the last few weeks of pregnancy. Here is another point: It is known that the foetal pituitary becomes active shortly before birth. Does the pituitary cause the onset of labour? This is pure speculation.

We all meet with instances of protracted pregnancy; even when the date of the last menstrual period is known beyond

possibility of error, there is no sign of the onset of labour at the end of the calculated 280 days. The longer the child remains in the uterus the larger it becomes and the harder is the head; pregnancy protracted beyond the normal period therefore brings danger of lacerations and injuries to the mother, and of intra-cranial hæmorrhages to the child. What are we to do in these cases? My own practice is to give an ounce of castor oil, and to order, as soon as the castor oil has acted, three doses of 10 gr. of quinine (30 gr. in all) to be given at intervals of two hours. Some obstetricians advise that this should be combined with intra-muscular injections of m^{iv} of a 10 per cent. solution of pituitary extract repeated if necessary at intervals of an hour for four or five doses. Personally, I believe the castor oil and quinine to be quite as effective without the pituitary, and the pituitary without the castor oil and quinine is certainly of very little value.

Never use pituitary after inducing with bougies or a bag. I was once called to a case where two bougies had been inserted, and later $7\frac{1}{2}$ m of 20 per cent. solution of pituitary had been exhibited. Rupture of the uterus resulted.

Now with regard to pituitary in the first stage of labour, save in one or two very exceptional cases, don't use it. Suppose you give the drug with the cervix three-quarters dilated, the child may be born after three or four severe pains, but it will tear through the cervix, not stretch it open. In certain cases of accidental hæmorrhage and in placenta prævia it is useful. Never give it in cases of concealed accidental hæmorrhage with albuminuria. This is essentially a toxæmia with necrosis of uterine muscle. If you prescribe it you may easily get a rupture of the uterus.

In the second stage there must be four indications before exhibiting the drug:

- (i) The head must be low in the pelvis.
- (ii) There must be no obstruction at the vulval orifice.
- (iii) The patient must be a multipara.
- (iv) Forceps must be ready boiled.

Never give more than 1 c.c. of 10 per cent. solution. This should be the maximum dose. After giving the drug watch the foetal heart. After fifteen minutes if the baby is not born, put on forceps and deliver. If before fifteen minutes there are variations in the foetal heart-rate, put on forceps immediately. I am in complete agreement with the writer who said: "To the mother who has borne children with an inability to deliver the child when the head is on the perinæum it is a boon; to the primipara in the first stage of labour a menace."

Eclampsia with a high blood-pressure is apparently not a contra-indication of pituitary.

One other question we must ask: Does pituitary affect the child? Dr. Ernest Holt has investigated the question. There is more danger of asphyxia livida or pallida after pituitary has been given. The proportion of stillbirths is larger after pituitary has been used. At autopsies on fatal

cases there are often meningeal and cerebral hæmorrhages. If these had not killed, they might easily have caused idiocy or epilepsy.

In the third stage of labour do not give the drug till the placenta has come away, or you may get hour-glass contraction. After delivery of the placenta, and especially with post-partum hæmorrhage, its effects are excellent. It acts quicker if injected into the uterus direct. After-pains are often relieved by pituitary.

Turning now to another function of the pituitary gland, we will study its rôle in the production of what is known as the "transient glycosuria of pregnancy."

We recognise three main types of cases in which sugar appears in the urine during pregnancy :

(1) *The alimentary type.* The urine contains glucose but there are no symptoms of polyuria, thirst or pruritus. The blood-sugar is scarcely if at all above the normal, and when the patient is dieted the glucose disappears from the urine.

(2) *True diabetes in pregnancy.* Here we have symptoms of polyuria, thirst, hunger and pruritus. The blood-sugar is high, and the urine-glucose is influenced by diet. The prognosis is very grave: diabetic coma often follows delivery.

(3) *The transient glycosuria of pregnancy.* There is glucose in the urine but there are no symptoms as in diabetes. The sugar is present in varying amount during the pregnancy; it disappears within a few days of delivery and recurs in subsequent pregnancies. Its amount is often increased by placing the patient on a carbohydrate-free diet. The blood-sugar is very little if at all higher than that of a normal pregnant woman. The condition need cause no anxiety.

Let me quote you a typical case of this last condition: A lady, æt. 21, was married in January, 1921. The last period was from July 28th to August 3rd, 1921, and she then became pregnant. On January 4th, 1922, glucose was found in her urine. There was no polyuria, no thirst, no hunger, no pruritus, and she felt well. On that date the sugar in the urine was '32 per cent.

She was dieted, and allowed only two small pieces of bread per diem; all sugar, cakes, sweets and potatoes were eliminated. In spite of this dieting, by February 10th the urine-sugar had increased to 3 per cent. I saw her at this time, and asked Dr. Mackenzie Wallis to estimate her blood-sugar. He found it only '12 per cent.—scarcely above the normal for a pregnant woman. We therefore put her back on a full carbohydrate diet, and in four days the urine-sugar had fallen to '07 per cent. Sugar persisted in her urine in varying amount throughout the pregnancy, and within a few days of delivery had disappeared completely. I have no doubt that, should she again become pregnant, it will reappear.

I need not point out to you the importance of diagnosis between these conditions when we remember the good

prognosis of the first and third and the grave prognosis of the second. You will gather further from what I have said that the crux of the matter lies in the estimation of the blood-sugar.

We believe that these transient glycosurias—symptomless, uninfluenced by diet, recurring in pregnancy after pregnancy, and associated with a normal blood-sugar—are the result of an increased activity of the pituitary body. This opinion is confirmed by the recent experimental work of Dr. Mackenzie Wallis. By his sugar-tolerance tests he has shown that after the administration of glucose the blood-sugar curves obtained in the transient glycosuria of pregnancy are identical with that obtained in the glycosuria of acromegaly.

I had hoped to touch on other effects of the pituitary upon pregnancy, such as its rôle in milk secretion, the limiting of the bitemporal visual fields by pressure of the enlarged anterior lobe on the optic chiasma, its relation to calcium retention to build up the foetal bones, and other points, but our time is gone.

I have tried to outline some of the relationships between the pituitary body and the reproductive system, in the hope that this may be of use to you in your practice. There is much to be said of the thyroid, the supra-renal, the thymus and the para-thyroids, and above all of the ovary itself when considered as an organ of internal secretion.

CHRONIC SCLEROSIS.

BY GEOFFREY EVANS, M.D., F.R.C.P.

THE regular advance in medical knowledge is largely the result of accurate observation and analysis of the complex problems that disease presents. A familiar example of achievement by this method (which has left its mark on the nomenclature of disease) was the separation of typhoid from typhus fever by Gerhard, of Philadelphia, in 1837. In 1896 Achard identified paratyphoid infections; later two forms of paratyphoid infection, A and B, were recognised by their serological and cultural differences, and more recently our knowledge has been extended by the identification of paratyphoid C.

Medicine advances most surely by regular short steps such as these, but occasionally in a hundred years a great discovery is made that throws a flood of light on problems unconnected with the immediate object of the original research. The work of Louis Pasteur, for instance, opened up a new vista in the causation of disease; the greatness of his achievement almost masks the method by which he gained success, but a study of his work shows him subjecting the most complex problems to acute analysis, and one of the results of this method was the discovery of the microbic origin of disease. It is rather remarkable that when the

greatest biologist of all time was still working on the problems of acute disease, a Russian savant of almost equal eminence, Elie Metchnikoff, was engaged on a problem of even greater magnitude in the study of chronic disease and senility. The two men are a striking contrast: Pasteur's mind was so centred on life that he became a protagonist in the controversy on spontaneous generation; Metchnikoff was so obsessed by the idea of the fear of death that he was led to apply the results of his investigations into the phenomena of inflammation to the elucidation of senility and premature death. Metchnikoff had his master's power of acute observation and analysis, but his imagination led him on to synthesis, and a truly grand obsession made him blame the large intestine for the disharmonies that he found in man. These two giants in biology appear as the prototypes of the analytic and synthetic mind; the one succeeded while the other in a measure failed.

The humblest worker among us who spends an hour at practical work or an hour in reflection must necessarily follow in the footsteps of Pasteur or Metchnikoff in exploring the fields of medicine. I sometimes think it is a strain of indolence that makes me welcome the synthetic idea. I well remember in my student days the joy of discovery that the treatment of arteriosclerosis and chronic interstitial nephritis detailed in different chapters of my text-book of medicine was almost identically the same. We all know very well the sense of bewilderment and fatigue when parties to a discussion on chronic kidney disease individually make use of such terms as large white, small white, contracting, contracted, granular, red granular, true red granular, arteriosclerotic and senile kidneys, chronic parenchymatous, mixed, diffuse and interstitial nephritis. Nor does this exhaust the possibilities, for there are types of chronic disease to which the names of distinguished physicians are attached, and the discovery of the "reine schrumpfnier" shows that future possibilities will not be curtailed by the limitations imposed by the English language. This confusion of terms is an incidental and temporary result of the application of the method of analysis, for each phrase or term has its own peculiar connotation, and signifies some particular clinical or pathological type that workers have attempted to isolate. Mere words lose their meaning in such an atmosphere of phrase, and if one of the parties to the discussion were to speak of chronic nephritis it is almost certain that he would be asked what he meant.

The subject presents an irresistible temptation to correlation or synthesis. It is tempting to class together in a single group all those forms of chronic kidney disease which show under the microscope the ordinary histological signs of chronic inflammation; so long as words retain their meaning it is tempting to call all these varieties of chronic kidney disease chronic nephritis simply. If this is accepted it follows that all these varieties of kidneys named are included in the term "chronic nephritis," excepting the

arteriosclerotic and the senile kidneys. This forms a simple basis from which to start, and the two exceptions to the common designation named above may be transferred from the realm of kidney to arterial disease.

It is impossible to escape from the close association of arterial and renal disease. Changes in the size and activity of the heart and variations in the blood-pressure are among the cardinal clinical signs of acute nephritis; the earliest pathological changes in the kidney in acute nephritis appear to be in the capillary nexus of the glomerular tufts (Herxheimer); arteriosclerosis is a common accompaniment of chronic nephritis; the connection, in fact, is so intimate that chronic nephritis cannot be considered without relation to arteriosclerosis. As in the case of chronic kidney disease, the understanding of chronic arterial disease owes much of its difficulty to the obscurity and diversity of its nomenclature. The problem of its causation is still obscure, but the nature of the affection of the arterial wall is one of inflammation. "Chronic arteritis" will displace the term "arteriosclerosis" when it is established to general satisfaction that the nature of the pathological process in arteriosclerosis is one of inflammation. Prof. Virchow was the first to propound the inflammatory theory of arteriosclerosis, and one of the difficulties in its acceptance has been the fact that the lesion differs in certain important respects from chronic inflammatory lesions in other tissues of the body. Thus small-cell infiltration is conspicuous by its absence, and degenerative changes often eclipse inflammatory reaction in the affected parts of the vessel-wall. This is, however, a possible explanation for this and other differences in the relatively poor blood supply of arterial walls, and the degree to which arteries are avascular structures must be settled by anatomists when the blood supply of these tissues is more accurately known. For the present I would accept the inflammatory theory of arteriosclerosis, and suggest that the simultaneous appearance of cellular proliferation, replacement fibrosis and degeneration is dependent on the adequacy of the supply of oxygen to the affected tissue-cells; those cells, such as the endothelial cells, which have a sufficient supply of oxygen have the power of responding to insult by proliferation while those cells, such as the deep tissue-cells of the intima, undergo degeneration because they exist in an avascular environment. Another important condition which may determine the type of lesion in a particular case may be the inherited or acquired vitality of the affected tissues; on such a theory the difference between diffuse hyperplastic sclerosis with its cardiac hypertrophy and raised blood-pressure on the one hand and senile arteriosclerosis on the other hand becomes one of tissue vitality varying with age.

On the hypothesis, then, that arteriosclerosis is chronic arteritis—and some would acknowledge the statement as a fact—the arteriosclerotic and senile kidney are seen to be forms of chronic inflammatory disease. In these two types

of kidney disease the chief affection is of the intimate vasculature of the kidney, and the renal parenchyma is held to suffer secondary degeneration and atrophy by starvation of its proper supply of blood. The same explanation has been given of the relation of arteriosclerosis to chronic nephritis—that is to say it has been held that arteriosclerosis causes chronic nephritis, while others hold that in certain cases chronic nephritis causes arteriosclerosis. There is a confused argument for and against both these views, and it cannot be said that the accumulation of accurate observation on the problem that these conflicting views present has led to any advance in our knowledge of the disease. On the other hand, there is some evidence for the opinion that both chronic arteritis and chronic nephritis are the result of the activity of the same pathogenic agents—that they are, in fact, alternative expressions of the same disease. Thus, when the kidneys bear the brunt of the affection the disease is chronic nephritis, and it may be noted that there are rare cases of death from kidney disease in which the kidneys are small, shrivelled and fibrotic, but without any appreciable arteriosclerosis in either the kidneys or other organs of the body; when the arteries bear the brunt of the affection the disease is arteriosclerosis—diffuse hyperplastic sclerosis or senile arteriosclerosis according to the vitality of the tissues of the arterial wall. The circumstances which determine the affection of the kidneys in one case, the arteries in another case and both arteries and kidneys in a third case is an interesting matter for speculation, but it does not affect the present postulate that chronic nephritis and arteriosclerosis are coincident or varying expressions of the same disease.

It is a clinical fact that some affection of the heart is a common accompaniment of arteriosclerosis and chronic nephritis. With a persistently raised systolic pressure there is cardiac hypertrophy particularly affecting the left ventricle; by taking a number of cases and plotting the systolic blood-pressures taken during life and the heart weight as measured after death, it can be shown that there is a definite relation between the height of the blood-pressure and the weight of the heart. It may be concluded that the cardiac hypertrophy is a compensatory phenomenon, secondary to a persistently raised blood-pressure. There is another familiar group of cases in which the cardiac affection is secondary to disease of the coronary arteries or their branches. Recent anatomical researches by Dr. Louis Gross have thrown new light on the vasculature of the heart, and emphasised the dependence of the conducting tissues on the integrity of the particular vessels that supply them. In some cases, which form a third group of interest in connection with the present thesis, there is a greater degree of cardiac hypertrophy than can be accounted for by the rise in systolic pressure—cases in which disease of the coronary circulation appears insufficient to account for the degree of cardiac affection that is present. In these cases it is suggested that the heart has suffered

simultaneously with the vessels, and that cardiosclerosis and arteriosclerosis have occurred coincidently as the result of the action of the same pathogenic agents.

It seems that in these lesions found post mortem and in such cases seen during life we are dealing with a disease of the cardio-vasculo-renal system, which may have its chief incidence on the pump, the hose or the nozzle in any particular case, while frequently the whole system is affected by the chronic inflammatory process. The cardio-vasculo-renal system is not, however, the only system affected in the morbid process of this disease. Osteoarthritis is a common accompaniment of arteriosclerosis, and the vascular lesion is so commonly present on post-mortem examination that it has been suggested, as in the case of chronic nephritis, that the chronic arthritis is secondary to chronic arteritis. Mr. A. G. Timbrell Fisher, in his recent Hunterian Lectures, describes the results of most interesting observations on the subject of osteoarthritis. He discards the view that the joint changes are secondary to arterial changes, and he explains the joint changes in terms of a chronic inflammatory process. His explanation of coincident proliferative and degenerative changes in terms of adequacy of oxygen supply to the affected tissue is well supported by anatomical and histological evidence, and the general similarity of the microscopical appearances of the joint lesion in osteoarthritis and the vascular lesion in arteriosclerosis provides additional evidence in favour of the inflammatory theory of arteriosclerosis.

In addition to chronic arthritis the frequent occurrence of glycosuria in arteriosclerosis seems to introduce the pancreas to the complex already described, and doubtless the same arguments as to the causal sequence of arteriosclerosis and pancreatic sclerosis have been or will be brought forward as has been done in discussing the relation of chronic nephritis to arteriosclerosis. The relation of emphysema to this complex needs discussion, but sufficient perhaps has been said to indicate the identity of a chronic inflammatory process called chronic sclerosis—a disease which is rarely limited to a single organ, and most often affects more than a single system. The centre of its attack most often falls on the cardio-vasculo-renal system, and this system may be affected in its entire extent or with a major incidence on the cardio-vascular or vasculo-renal parts. It seems at present that the process of disease is by no means general, and that the liver and brain for instance commonly escape attack. In order to give chronic sclerosis identity as a disease it may be compared to gout, which it resembles in so many respects that the differential diagnosis may be difficult when the characteristic joint lesions and tophi of gout are not manifest. The recognition of chronic sclerosis has the advantage of focussing the attention of the clinician on the whole group of organs and systems commonly affected when attention has been drawn by signs or symptoms to any one of them. It also helps to place

arteriosclerosis in proper proportion to sclerosis elsewhere in the body. Arteriosclerosis appears as the centre of the complex as a whole, as it is the centre of cardio-vascular sclerosis; this suggestion, however, may be prejudiced, for, as Fielding said, "Every physician, almost, hath his favourite disease." Finally chronic sclerosis, in whatever form it may appear, determines a general line of treatment in respect of environment, work, habits, diet and elimination and a certain attitude in prognosis which is a good foundation on which to build the special course of therapy that the case requires.

STUDENTS' UNION.

LAWN TENNIS CLUB.

Results of the 2nd VI.

v. GALLERY L.T.C.

Lost, 0-9. G. K. Loveday and A. V. Mackenzie lost to Bailey and Bartlett, 2-6, 10-12; lost to Atwell and Bowers, 3-6, 6-3, 3-6; lost to Patience and Brumwell, 0-6, 6-2, 1-6. W. Joule and B. W. Brown lost to Bailey and Bartlett, 4-6, 4-6; lost to Atwell and Bowers, 1-6, 1-6; lost to Patience and Brumwell, 0-6, 5-7. R. A. P. Corkery and A. Q. Wells lost to Bailey and Bartlett, 1-6, 0-6; lost to Atwell and Bowers, 1-6, 1-6; lost to Patience and Brumwell, 1-6, 1-6.

v. MIDDLESEX HOSPITAL.

Won 9-0. G. K. Loveday and A. V. Mackenzie beat Nicholson and Sladen, 6-0, 6-2; beat Scarff and Escourt, 6-2, 6-2; beat Grey and Chissell, 6-2, 6-0. J. D. M. Stewart and W. Brown beat Nicholson and Sladen, 7-5, 9-7; beat Scarff and Escourt, 4-6, 6-2, 6-3; beat Grey and Chissell, 6-1, 6-1. G. H. Caiger and A. Davenport beat Nicholson and Sladen, 6-3, 6-0; beat Scarff and Escourt, 6-2, 6-1; beat Grey and Chissell, 6-2, 6-1.

v. UNIVERSITY COLLEGE HOSPITAL.

Won, 5-4. W. Joule and W. Brown lost to Pair No. 1, 1-6, 8-6, 1-6; beat Pair No. 2, 6-4, 6-3; beat Pair No. 3, 6-4, 6-8, 7-5. A. Q. Wells and G. S. Morgan lost to Pair No. 1, 4-6, 4-6; lost to Pair No. 2, 5-7, 5-7; lost to Pair No. 3, 0-6, 6-4, 4-6. J. A. Macfadyen and R. H. Knight beat Pair No. 1, 4-6, 6-2, 6-4; beat Pair No. 2, 6-3, 8-6; beat Pair No. 3, 6-3, 6-4.

v. HIGHGATE L.T.C.

Lost, 7-1, two matches drawn. A. V. Mackenzie and A. C. Davenport lost to Hepworth and Murphy, 4-6, 5-7; beat Read and Cusop, 6-4, 6-1; drew with Bush and Bush, 4-6, 7-5. G. S. Morgan and R. H. Knight lost to Hepworth and Murphy, 3-6, 3-6; lost to Reed and Cusop, 1-6, 4-6; lost to Bush and Bush, 4-6, 6-4, 3-6. A. C. Liesching and R. Green lost to Reed and Cusop, 6-1, 6-3; lost to Bush and Bush, 2-6, 6-3, 2-6.

v. LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE.

Won, 5-0. K. Loveday and W. Joule beat Hornsby and Markini, 6-4, 6-4; beat Stanton and Nicholls, 6-1, 6-1. G. S. Morgan and J. A. Macfadyen beat Hornsby and Markini, 6-4, 4-6, 6-4; beat Stanton and Nicholls, 6-1, 6-1. R. Green and N. A. Jory beat Stanton and Nicholls, 6-4, 6-0.

Inter-Hospital Cup.

v. KING'S COLLEGE HOSPITAL.

The 2nd VI met King's College Hospital in the first round of the Inter-Hospital Cup and won by 8 matches to 6. As the score indicates it was most keenly fought, and had it not been for the slight advantage we held in the doubles matches we should most certainly have failed.

Singles.—K. Loveday v. Kohnstann, 2-6, 3-6; A. V. Mackenzie v. Collins, 6-3, 6-2; G. H. Caiger v. Porter, 1-6, 3-6; B. W. Brown v. Rice, 4-6, 1-6; J. D. M. Stewart v. Dyer, 6-4, 6-1; A. C. Davenport v. Morgan, not played. Bart's, 2 matches; King's 3.

Doubles.—G. K. Loveday and A. V. Mackenzie beat Kohnstann and Porter, 6-2, 6-3; beat Collins and Dyer, 6-2, 6-2; beat Rice and Morgan, 6-1, 6-4. W. Brown and J. D. Stewart lost to Kohnstann and Porter, 3-6, 2-6; beat Collins and Dyer, 6-2, 8-6; lost to Rice and Morgan, 3-6, 0-6. A. C. Davenport and G. H. Caiger lost to Kohnstann and Porter, 3-6, 4-6; beat Collins and Dyer, 6-1, 6-4; beat Rice and Morgan, 6-3, 6-4. Bart's, 6 matches; Kings', 3.

v. GUY'S HOSPITAL.

In the second round we met Guy's Hospital and were beaten 10 matches to 2. It was a most disappointing result because as a team we were capable of better things. Guy's are not unbeatable, and it should have been a very close match, not that one wishes to depreciate the value of our opponents, who were a better team both in singles and doubles.

Singles.—G. K. Loveday v. Phillips, 0-6, 1-6; A. V. Mackenzie v. Morgan, 4-6, 6-8; G. H. Caiger v. Potts, 2-6, 0-6; B. W. Brown v. Sharpey, 2-6, 0-6; W. Joule v. Laver, 2-6, 2-6; J. D. M. Stewart v. Gordon, 4-6, 6-3, 6-4. Bart's 1 match, Guy's 5 matches.

Doubles.—K. Loveday and A. V. Mackenzie lost to Phillips and Morgan, 1-6, 6-3, 4-6; lost to Potts and Sharp, 7-5, 6-8, 3-6. S. A. Macfadyen and G. Caiger lost to Potts and Sharp, 1-6, 0-6; beat Gordon and Laver, 7-5, 5-7, 6-4. W. Joule and B. W. Brown lost to Phillips and Morgan, 1-6, 2-6; lost to Gordon and Laver, 5-7, 2-6.

This season was not altogether a crowning success. More matches were arranged but the elements were against us. Then the general enthusiasm which reigned at the commencement of the season was not kept up. Why? We don't know, except that it simply died a natural death. It was never general except for a few energetic ones who did their best to keep things going. We therefore strongly urge that all members of clubs should take a more active and livelier interest in their games to help in an endeavour to place "Bart's" where she should be, and not where she is as compared with the other hospitals of London.

GOLF CLUB.

The match *versus* the London Hospital in the Semi-final of the Inter-Hospital Golf, which was played off at Sandy Lodge on July 11th, 1922, resulted in a win for Bart's.

ST. BARTHOLOMEW'S HOSPITAL.	LONDON HOSPITAL.
C. H. Prall 0	A. R. Lister (1 up) 1
J. H. T. Davies (5 & 3) 1	F. Valentine 0
J. Ness Walker (4 & 2) 1	B. Thompson 0
H. F. Chillingworth 0	W. G. Lister (7 & 6) 1
J. L. Potts (4 & 3) 1	J. Burrell 0
R. Stuart Low (3 & 1) 1	J. Trevor 0

Prall and Davies 0	A. R. Lister and Valentine 1
Walker and Potts (1 up) 1	W. G. Lister and Thompson 0
Chillingworth and Stuart Low 1	Trevor and Burrell 1
5½	3½

STUDENTS' CHRISTIAN UNION.

A WEEK-END camp was held at Addington, near Croydon, from July 23rd-25th.

Mr. J. B. Hume, F.R.C.S., was kind enough to come down as Camp Commandant, and the Assistant Hospitalier came as Chaplain. We numbered fourteen Bart's men in all.

The weather was kind, and everyone had a thoroughly enjoyable time.

REVIEWS.

MEDICAL SCIENCE: ABSTRACTS AND REVIEWS. May, June, July, 1922. (The Medical Research Council: Humphrey Milford, Oxford University Press.) Each 3s. net, or annual subscription 30s. post free.

Three numbers of this admirable periodical lie before us. It will be sufficient to mention the chief contents.

In the May number are articles on "Acute Rheumatism and Rheumatoid Affections," "Cerebro-spinal Fever," "Chancroid"; in June there is a masterly *précis* of the recent literature on syphilis; and in July "Diseases of the Liver," "Intestinal Parasites," and "Some Recent Work on the Corpus Striatum" are found.

In each issue there are the usual very full abstracts of recent work on all medical subjects.

THE THRESHOLD OF MOTHERHOOD: HANDBOOK FOR THE PREGNANT WOMAN. By R. DOUGLAS HOWAT, L.R.C.P.(Edin.), L.R.C.S.(Edin.). (Glasgow: Maclellan, Jackson & Co.) Pp. 49. Price 3s. 6d.

Any book talking sense to the pregnant woman about her condition, and not costing too much, is to be welcomed, especially if, as in the present volume, there is a refreshing absence of that sentimentalism which often spoils such works. There are, however, two serious criticisms—one of commission, the other of omission. We do not think that a medical man should advise a woman only to engage a doctor for her confinement who will promise to give her chloroform during labour. Medical men must not be under the dictation of patients with regard to treatment. Often enough chloroform is not indicated; sometimes it is contra-indicated. There is no mention of that thorough medical examination at least once during pregnancy upon which modern obstetricians should insist, and upon the need of which the public is so badly educated.

Apart from these faults the book is good.

OTO-RHINO-LARYNGOLOGY FOR THE STUDENT AND PRACTITIONER. By Dr. GEORGES LAURENS. Translated by H. CLAYTON FOX, F.R.C.S.(Irel.). (John Wright & Sons, Ltd.) 2nd English edition. 589 illustrations. Pp. 350. Price 17s. 6d. net.

The French mind seems particularly able to set forth scientific facts with absolute clearness. This clarity of thought and of expression, the exactness of detail in applying the simplest piece of technique, the extraordinary wealth of illuminating illustrations, are the dominating features of a very excellent book. The writer covers the ground in an extensive fashion, only stopping at the point where proceedings should be taken in hand by a consultant, where work has to be performed which only years of experience can justify. Till this point is reached the book is a valuable mine of information for student or practitioner. It must be of extraordinary value to the house-surgeon in this department.

Particularly do we like the author's method of stating, after he has told the reader what to advise and do in any given circumstance, what to avoid. It is difficult in a book so uniformly good to point out special excellences. The chapters on the larynx make a difficult subject easy. Interesting and sometimes forgotten is his differentiation between Ménière's disease (vertigo caused by hæmorrhage into the labyrinth, and very rare) and Ménière's syndrome (vertigo, deafness, and tinnitus caused by any irritation of the labyrinth). We think that perhaps a little more pathology might be helpful, and surely the treatment of dysphagia due to tuberculosis of the larynx by anæsthesia of the superior laryngeal nerve is a specialised manoeuvre? But these are small points in a remarkably able book. We congratulate the translator on his success.

A TREATISE ON GLAUCOMA. By ROBERT HENRY ELLIOT, M.D., B.S.(Lond.), Sc.D.(Edin.), F.R.C.S.(Eng.). (London: Henry Frowde and Hodder & Stoughton.) With 213 illustrations. Pp. 656. Price 30s. net.

This great work on a special disease of a special department must command respect and interest, not only because it is obvious that no effort has been spared by author or publisher to render it as complete

as possible, but also because the name of the writer will always be associated with the operation of corneo-scleral trephining for the cure of the condition. Col. Elliot's experience in India (surely a paradise for the ophthalmologist) has given him an immense opportunity for research in eye conditions, and the wisdom of many years is found in the book before us.

The length of the volume will indicate its scope. It aims at being a full and complete account of glaucoma. Many points of an historical nature are added. Its very completeness, whilst rendering it invaluable to the ophthalmologist, makes it unsuitable for the student.

Where all is good, full, well written, and dictated by the actual practice and belief of the writer, it is difficult to pick out any section for special praise, but probably the 144 pages devoted to operative treatment will be specially valuable to the surgeon. The smaller points of technique are admirably elucidated, and the emphatic advice to operate early in spite of risks is a lesson which cannot be too well learnt. There are many dangers in operating. A bad result, often in spite of, and not because of, the surgeon, brings blame upon him; non-interference and slowly progressing blindness may be forgiven. But glaucoma is a disease in which often professional risks must be undertaken for the patient's good.

CATARACT AND ITS TREATMENT. By HENRY KIRKPATRICK, M.B. (London: Henry Frowde and Hodder & Stoughton.) Illustrated. Pp. 201. Price 12s. 6d.

This volume, also by a retired I.M.S. colonel, is a less ambitious attempt to write a complete account of one ophthalmic condition. The book is well prepared, and is not too large to be outside the range of the keen student or ophthalmic house-surgeon. It contains little that is new, but is a good, clear and careful account of the subject. It excels in the description of treatment before operation—although advice is modelled on the practice in an Indian hospital—and the after-treatment, with an account of the complications occurring after operation.

THE OPHTHALMOLOGY OF GENERAL PRACTICE. By MALCOLM L. HEPBURN, M.D.(Lond.), F.R.C.S.(Eng.). (Cassell & Co., Ltd.) With 40 colour and 9 half-tone illustrations. Pp. 183. Price 12s. 6d. net.

This is a very good book indeed. The object of the writer is to enable the general practitioner to distinguish between cases which he should be able to treat himself with success and those which must be referred to a specialist. We think that the writer has admirably succeeded in his aim.

The volume commences with preliminary chapters on "The Examination of the Eye," "Urgent Cases in General Practice," "Drugs in Ocular Diseases," and "Operations," which will repay careful and repeated attention. Thence he proceeds on the usual anatomical basis of classification.

There is one chapter which we hope in future editions may be amplified—that on "Errors of Refraction and Accommodation, and Eye-strain." Those who have ever been in general practice will well realise what a source of income must often be neglected through sheer ignorance, and will desire more information on this subject.

The illustrations are excellent.

PHYSICAL EXAMINATION OF THE CHEST, WITH SPECIAL REFERENCE TO PULMONARY TUBERCULOSIS, INCLUDING A CHAPTER ON TUBERCULOSIS OF THE LARYNX. By JAMES CROCKET, M.D., D.P.H. (London: H. K. Lewis & Co., Ltd.) Cr. 8vo. Pp. viii + 254, 56 illustrations, including 14 plates. Price 9s. net.

Though the title of this book implies that the whole chest is considered, the subject matter deals only with the lungs, pleurae, and such changes in the rest of the chest as are secondary to pulmonary disease. There are many useful hints in the detailed account given, particularly in the chapter on inspection. It is well known that no two teachers employ the same nomenclature, and it is therefore useless to criticise this. We must, however, protest against the statement, apropos of *adles*, that "the term 'subcrepitant' is quite expressive of what is meant"; to most students, we feel sure, this

adjective is meaningless. From what must surely be an extraordinary oversight, the discussion of vocal resonance is completely omitted (though vocal fremitus is considered fully); the word "bronchophony" is not to be found anywhere. Nor does the author give any hint that he disapproves of this method of physical examination. There is a useful chapter on X-ray diagnosis, and a particularly good one (with 17 figures) on the larynx in tuberculosis.

TAYLOR'S PRACTICE OF MEDICINE. By E. P. POULTON, M.D., F.R.C.P., with the assistance of C. P. SYMONDS, M.D., M.R.C.P., and H. W. BARBER, B.A., M.B., F.R.C.P. Twelfth Edition. (London: J. & A. Churchill.) Pp. xiv + 980, 24 plates and 87 text-figures. Price 30s. net.

A great deal of careful work has evidently been put into the revision of this book by Dr. Poulton and his colleagues. The fact

that two colleagues had to be called in perhaps indicates, as is suggested in the preface, that a text-book on medicine can never again be tackled by one man. There is little which has not had to be revised or added to since the last edition in 1918. As we read each section we keep noticing additions which have been incorporated from the most recent literature. There is an appendix dealing with the Schick test, van den Bergh's test in jaundice, and rapid treatment with digitalis.

In contrast to the general excellence, two sections struck us as very inadequate, those on the treatment of empyema and the pathology of purpura (where blood-platelets are never mentioned). The value of clubbed fingers in the diagnosis of malignant endocarditis is not referred to; on p. 612 "Planorbis boisoyi" should read "boissyi." If asked to draw invidious comparisons between "Taylor" and the equally well-known "Osler," we should advise the student, in view of the rapidity with which medical knowledge grows, to buy whichever of the two has the more recent edition.

HOURS OF ATTENDANCE AT THE HOSPITAL OUT-PATIENT DEPARTMENTS.

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
General Medical	Dr. Hinds Howell 10 a.m.	Dr. Geoffrey Evans 10 a.m.	Dr. Langdon Brown 10 a.m.	Dr. Gow 10 a.m.	Prof. Fraser 10 a.m.	Dr. Thursfield 10 a.m.
General Surgical	Prof. Gask 10 a.m.	Mr. Vick 10 a.m.	Mr. Wilson 10 a.m.	Mr. Dunhill 10 a.m.	Mr. Roberts 10 a.m.	Mr. Girling Ball 10 a.m.
Gynæcology	Dr. Barris 9 a.m.	—	Dr. Donaldson 1.30 p.m.	Dr. Barris (Ante-natal Clinic) 1.30 p.m.	—	Dr. Donaldson 9 a.m.
Ophthalmology	Mr. Holmes Spicer 1 p.m.	Mr. Foster Moore 1 p.m.	—	Mr. Holmes Spicer 1 p.m.	Mr. Foster Moore 1 p.m.	—
Laryngology	Mr. Harmer 1 p.m.	Mr. Rose 9 a.m.	—	Mr. Harmer 9 a.m.	Mr. Rose 1 p.m.	—
Otology	Mr. Scott 1 p.m.	Mr. Just 9 a.m.	—	Mr. Scott 9 a.m.	Mr. Just 1 p.m.	—
Orthopædics	Mr. Elmslie 1 p.m.	—	—	Mr. Elmslie 1 p.m.	—	—
Dermatology	—	Dr. Adamson 9 a.m.	Dr. Adamson 9 a.m.	—	Dr. Adamson 9 a.m.	—
Diseases of Children	Dr. Thursfield 1.30 p.m.	—	Dr. Morley Fletcher 1.30 p.m.	—	—	—
Electrical Therapeutics	Dr. Cumberbatch (Men) 1 p.m.	Dr. Cumberbatch (Women) 1 p.m.	—	Dr. Cumberbatch (Men) 1 p.m.	Dr. Cumberbatch (Women) 1 p.m.	—
Dentistry	Mr. Fairbank 9 a.m.	Mr. Fairbank 9 a.m. Mr. Ackland 10 a.m.	Mr. Coleman 9 a.m.	Mr. Fairbank 9 a.m.	Mr. Coleman 9 a.m. Dr. Austen 10 a.m.	Mr. Coleman 9 a.m.
Psychological Medicine	—	—	—	—	Dr. Porter Phillips 2 p.m.	—
Venereal Diseases (Golden Lane)	Women and children 12 to 2 p.m.	—	Men 12 to 2 p.m.	Women and children 12 to 2 p.m.	Men 5 p.m. to 7 p.m.	—
Tuberculosis Dispensary	6 p.m.	12.30 p.m.	—	6 p.m.	12.30 p.m.	—
X-Rays	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.
Exercises and Massage	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. to 1 p.m.	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. to 1 p.m.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degrees have been conferred:

D.M.—G. H. Rossdale.

M.S.—E. A. Crook.

B.M.—W. Champneys.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

M.D.—I. de B. Daly, A. B. Appleton.

UNIVERSITY OF LONDON.

M.D. Examination, July, 1922.

Branch I: Medicine.—F. E. S. Willis.

Branch IV: Midwifery and Diseases of Women.—G. F. Cooke.

Branch VI: Tropical Medicine.—C. V. Boland.

Second Examination for Medical Degrees. Part II.

(For Internal and External Students.)

J. S. Aldridge, H. G. Anderson, H. I. C. Balfour, C. F. J. Baron, J. R. Beagley, F. P. O. Bridgeman, E. Büchler, J. B. Crabtree, M. Fishman, F. G. Greenwood, A. Gross, H. F. Hiscocks, W. Holdsworth, A. C. Liesching, G. K. Loveday, I. S. Moscow, C. E. Pearsons, M. D. Rawkins, D. E. Thomas, R. W. H. Tincker.

LONDON SCHOOL OF TROPICAL MEDICINE.

The following candidates passed the examination held at the termination of the Sixty-ninth (April–July, 1922) Session:
Lieut.-Col. S. Hunt, I.M.S., C. Dunscombe.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

D.P.H.

The *Diploma in Public Health* has been conferred upon:

H. Toms, D. S. Brachman, A. M. ElKirdany.

D.P.M.

The *Diploma in Psychological Medicine* has been conferred upon:
J. J. Gasperine.

SOCIETY OF APOTHECARIES.

The Diploma of the Society was conferred on:
T. Adam.

APPOINTMENTS.

BARNES, E. B., M.R.C.S., L.R.C.P., appointed Medical Officer to the Throat and Ear Ward, Ministry of Pensions Hospital, Orpington.

COURT, E. P., M.R.C.S., L.R.C.P., appointed Deputy Medical Superintendent, Borough Mental Hospital, Rowditch, Derby.

DANNATT, M., M.B., B.S.(Lond.), appointed Deputy Medical Superintendent, Camberwell Infirmary.

EVANS, D. B., M.R.C.S., L.R.C.P., appointed Medical Superintendent to the Standish House Sanatorium for Tuberculosis, Stonehouse.

GRAY, A., F.R.C.S.(Eng.), M.R.C.P.(Edin.), appointed Assistant Physician for Diseases of Women, London Homœopathic Hospital, Great Ormond Street, and Queen Square.

MATTHEWS, E. A. C., Lt.-Col. I.M.S., D.S.O., M.B., B.Ch.(Cantab.), appointed to the Command of Palestine General Hospital, Ludd, Palestine.

WHITEHEAD, F. E., M.R.C.S., L.R.C.P., appointed Senior Medical Officer, Nyasaland, British Central Africa.

WOODFORDE, A. W. G., M.B., B.S.(Lond.), appointed Hon. Assistant Surgeon, and Hon. Assistant Orthopaedic Surgeon, to St. Bartholomew's Hospital, Rochester.

CHANGES OF ADDRESS.

BARNES, E. B., Ministry of Pensions Hospital, Orpington.

BURSTAL, E., 46, Lansdowne Road, Bournemouth.

COOK, A. R., Melrose, 8, South Park Hill Road, S. Croydon (temporary).

COURT, E. P., Borough Mental Hospital, Rowditch, Derby.

CROOK, E. A., 136, Harley Street, W. 1. (Tel. Mayfair 6397.)

CROWLEY, R. H., New Town Hostel, Welwyn Garden City, Herts.

DANNATT, M., Camberwell Infirmary, Brunswick Square, Camberwell, S.E. 5.

DAVIES, S. TREVOR, Tuberculosis Dispensary, 140, West Green Road, Tottenham, N. 15.

DUPRÉ, W. H., St. Just, nr. Penzance, Cornwall.

EVANS, D. B., Standish House, Stonehouse, Glos. (Tel. Stonehouse 176.)

FOOKS, G. E., Lt.-Col. I.M.S., Upton, Bangalore, India.

GRAHAM, G., 1, Devonshire Place, W. 1. (Tel. Mayfair 6407.)

LEE, W. E., 17, Prince's Avenue, Muswell Hill, N.

MACKENZIE, K. A. I., Surg.-Lt. R.N., Lansdowne House, Ryde, Isle of Wight.

MATTHEWS, E. A. C., Lt.-Col. I.M.S., D.S.O., Palestine General Hospital, Ludd, Palestine.

VINTER, N. S. B., c/o Post Office, Charlestown, Nevis, B.W.I.

WHITEHEAD, F. E., Medical Department, Nyasaland, British Central Africa.

BIRTHS.

BARNES.—On June 26th, at Wiltshire House, Wiltshire Road, S.W. 9, Frances (*née* Norman), wife of Howell Wood Barnes, B.A., M.B., B.Ch.(Cantab.), M.O.H., Metropolitan Borough of Camberwell—of a daughter (Sybil Mary).

BROUGHTON-ALCOCK.—On June 28th, at 20, Grosvenor Street, W. 1, to Dr. and Mrs. W. Broughton-Alcock—a daughter.

GILBERTSON.—On June 26th, at Bancroft, Hitchin, Herts, the wife of Dr. H. Marshall Gilbertson—of a daughter.

MATHER.—On June 18th, at 79, Linden Road, Bournville, Birmingham, to Alice, the wife of Edward E. Mather, M.B.—a son.

PRENTICE.—On July 9th, at Seacliffe, Kingsgate, Kent, to Margaret, wife of H. Ridley Prentice, M.B., M.R.C.P.—twin sons.

ROSSDALE.—On June 26th, to Kate, wife of Dr. George Rossdale, of 57, Upper Berkeley Street—a daughter.

MARRIAGES.

BALLINGALL-CHANDLER.—On May 3rd, 1922, at St. George's Cathedral, Jerusalem, Palestine, by the Right Reverend the Bishop of Jerusalem, Captain David Charles Gordon Ballingall, M.C., R.A.M.C., eldest son of the late Charles Gulland Ballingall and Mrs. C. G. Ballingall, Hampstead, London, and Rosa Beatrice Chandler, eldest daughter of Mr. and Mrs. A. B. Chandler, formerly of Seagry, Chippenham, Wilts.

CHAMBERLAIN-CLEMENTS.—On July 22nd, at St. Giles' Registry Office, W., Arthur George Chamberlain to Mary Eileen Emélie Clements.

EMMERSON-PETO.—On July 1st, at St. Mary Abbot's, Kensington, by the Rev. R. W. Bell, Cuthbert Lindsay Emmerson (Capt., R.A.M.C.), only son of the late Dr. Emmerson, of Biggleswade, Beds, to Gladys Emma, only daughter of the late Mr. William Peto and Mrs. Peto, of Canon Court, Maidenhead.

DEATH.

TOSWILL.—On July 7th, 1922, at 5, Clifton Hill, Exeter, Louis Henry Toswill, M.B.(Cantab.), aged 79.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C.

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